

## *Partners in Practice*

### **Beyond the boundaries: relationship between general practice and complementary medicine**

Patrick C Pietroni

*This is the seventh of a series of articles focusing on the current tasks and functions of the primary health care team*

Traditional medical partnerships were designed to operate in a stable unchanging environment. It is clear that the next five years will be neither stable nor unchanging within primary health and community care. General practitioners for the first time are operating within a managed health service, and the autonomy they once had to determine their administrative routines is rapidly disappearing.

These changes will inevitably challenge the organisational structures currently found in general practice. Inevitably, nurses, social workers, counsellors, midwives, health visitors, and dieticians will demand a place within an integrated health care team, and general practice will have to adapt. At the same time the increasing popularity of some of the complementary therapies will continue and we will have to address the question as to their relevance to the delivery of care within the community.

#### **Relationships between general practitioners and complementary practitioners**

##### DEFINITIONS

One of the problems faced in exploring the relations between general practitioners and complementary practitioners is that there is no clear definition of words such as "alternative," "complementary," "holistic," "natural," and "fringe," which are often used to describe vastly dissimilar activities. Much confusion arises from the belief that holistic medicine and alternative medicine are the same thing. There are as many general practitioners who apply the principles of a holistic approach to their patients as there are acupuncturists who do not. The term "alternative" or "complementary" medicine is used as a catch all definition for anything not taught at a Western medical school. It is thus a definition by exclusion and as helpful a term as "foreign." An Englishman setting out to comment on "foreigners" would be as accurate in his description of foreigners as most doctors are in their understanding of alternative therapies, and the Englishman's commentaries on foreigners would tell us more about the prejudices of being English than the characteristics of non-English people. The classification that I find most helpful divides the vast subject of complementary therapies into four distinct areas<sup>1</sup>:

- Complete systems
- Diagnostic methods
- Therapeutic modalities
- Self care approaches.

#### **Examples of treatments in four areas of complementary therapy**

##### *Complete systems*

Homoeopathy, osteopathy, herbal medicine, acupuncture

##### *Diagnostic methods*

Iridology, kinesiology, hair analysis, aura diagnosis

##### *Therapeutic modalities*

Massage, shiatsu, reflexology

##### *Self care approaches*

Meditation, yoga, relaxation, dietetics

Some of the methods that fall into these categories require four years of full time training akin to undergraduate medical school, while others can be learnt and applied after a few weekend seminars. It is inappropriate and does reasoned debate an injustice to lump all these categories together under one definition and respond with a prejudiced or enthusiastic stance.

It is outside the scope of this article to examine the burgeoning field of complementary medicine, but it is clear the general practitioner will require some guidance from an authoritative and unprejudiced source before deciding which treatments to consider including in their expanded primary health care service. Research at Marylebone Health Centre has begun to provide some guidance.<sup>2,4</sup>

#### **The growth of complementary medicine**

A survey in the United Kingdom in 1982 identified a total of 30 000 complementary practitioners of one sort or another.<sup>5</sup> Subsequent developments have suggested a growth of 10% a year, which would make the present figure nearer 50 000. The consumer magazine *Which?*, in its survey of almost 2000 readers, found that one in seven had visited a complementary therapist in the past year.<sup>6</sup> A survey undertaken by the Market and Opinion Research Institute (MORI) in 1989 showed that 74% of the sample surveyed (1826 adults) would have liked to see some form of complementary medicine introduced into the health service.<sup>7</sup> The interest among general practitioners has increased in the past 10 years. Reilly found a positive attitude towards complementary medicine in 86 of 100 general practitioner trainees in 1982,<sup>8</sup> and Wharton and Lewith, in their survey of

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200 general practitioners in the Avon district, found that 38% had received some additional training in one form of complementary therapy.<sup>9</sup>

Clinical outcome and research papers in several areas of complementary therapy now find a place in orthodox medical journals, and it is no longer possible to maintain the traditional medical stance that referring patients to complementary therapists is unethical. The pressure for including some form of complementary therapy within the health service will continue to increase as a result of the King's Fund report on osteopathy.<sup>10</sup> In a recent open letter the junior health minister supports the view that general practitioners can employ complementary therapists in their practices as long as they retain clinical responsibility.

### Power, conflict, and collaboration

This history of "outsider" or "alternative" medicine is as long as history itself. It could be said that for a while general practice was viewed as alternative medicine or as an unacceptable alternative to medicine. Many of us were told that we were selling ourselves short, we had fallen off the ladder, if we embarked on a career in general practice. Lord Moran's comments on the establishment of the Royal College of General Practitioners in the 1950s still rankles with senior colleagues. "Over my dead body," he said. General practice, of all disciplines, should be sensitive to the views of colleagues in complementary medicine who experience the same arrogance and ignorance from doctors. But the antipathy goes much further back and the language is much richer, as the following description from the seventeenth century shows.

But our Empirics and imposters, as they are too ignorant either to teach or to practise Physic . . . and too insolent, and too arrogant to learn of the Masters of that Faculty, or to be reduced into order: so are they most dangerous and pernicious unto the Weale public. . . . These Crocodiles, disguised with the vizard of feigned knowledge and masking under the specious titles of Physicians and Doctors, not attained in Schools, but imposed by the common people, do with the Absolonically Salutations steal away the affections of the inconstant multitude, from the Learned Professors of that Faculty, with their loablike Imbracings, stab to the heart their poor and silly patients, ere they be aware of once suspect such uncouth Treachery.<sup>11</sup>

More recently, studies undertaken at Marylebone Health Centre have shown a less fraught but equally difficult pattern of relations between general practitioners and complementary practitioners. Issues identified in these studies included the following<sup>12 13</sup>:

- The variety of clinical models informing the different practitioners, which led to different assumptions about outcome
- The nature of the referral process and the power issues implied by the general practitioner acting as the only gatekeeper
- Organisational conflicts that arise out of the appropriate allocation of resources (rooms, funds, secretarial help, etc)
- Empowerment of patients and the subsequent disempowerment of practitioners.

No one group can hope to resolve these problems, and more research is required before recommendations about the integration of complementary medicine into general practice are made.

### Options for changes

The following are some possible options for the integration of complementary medicine into general practice.

#### TRADITIONAL

*Ancillary staff funding by family health services authorities*—Complementary practitioners can now be employed like any other ancillary staff if general practitioners can persuade the family health services authority to provide the reimbursement. They operate within the health centre, in a similar manner to physiotherapists or counsellors—that is, patients are referred by general practitioners, who retain clinical responsibility. All complementary practitioners employed at Marylebone Health Centre (practitioners in massage, osteopathy, acupuncture, herbal medicine, and homoeopathy) operate under this model. Levels of pay are determined and set by the practice to reflect experience and status—for example, massage practitioners are on the same scale as a clinical nurse specialist and osteopaths are on a clinical assistant grade. The family health services authority reimburses 60%-70% of their pay and the rest is supported through health promotion reimbursement (this will change following recent legislation).

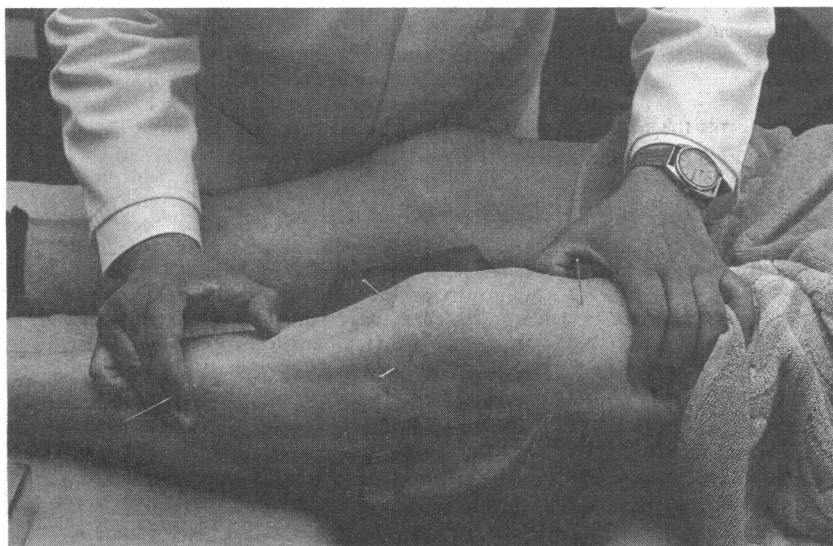
*Privately funded*—Complementary practitioners are referred patients privately, in a similar manner to other specialist services. Some practices have provided free space within the practice for private work in exchange for two to three NHS patient referrals a week. Other groups have shared premises and have cross referrals from both groups.

*Research studies* to explore the use of complementary therapies in general practice are now more easily funded and it is possible to receive both regional and district funding for such activities (the work at Marylebone Health Centre began in this way).

*Local fundraising activities*—The need to develop services through charity and voluntary contributions begs many questions, yet it can prove to be the only way in which services can be supported. Several groups have employed complementary practitioners in this way.

*Direct funding*—Some district health authorities and family health services authorities have employed osteopaths, massage practitioners, and counsellors directly themselves and then seconded them to those practices that are in a position to make use of them. Fundholding practices are clearly able to do this themselves.

*Practice placements*—Marylebone offers a six months' massage training course during which time the candidates have to work for 40 hours in a general practice. These practice placements are "free" and offer both the student and the practice an opportunity



SUE DE JONG/FORMAT

*It is no longer considered unethical to refer patients to complimentary practitioners*

### Key points

- There is a need to define precisely the various terms used when referring to complementary medicine
- Many areas of complementary medicine are now accepted by patients, some general practitioners, orthodox medical journals, and politicians
- Possible ways of integrating complementary medicine and general practice need to be explored
- Integration could be traditional, with the general practitioner retaining the role of sole gatekeeper, or could be part of a move towards a multiprofessional practice

to explore and develop experience in their particular therapy. Links with other training establishments are currently in progress to expand this scheme.

**Primary health care referral centre**—Many practices wishing to cooperate with complementary practitioners are unable to because of lack of space. One health authority is exploring the possibility of providing a referral centre for five or six practices from which complementary therapy, counselling, and other additional services can be provided.

### EXPERIMENTAL

All the previous models maintain the traditional relationship between the general practitioner and the complementary practitioner—that is, the general practitioner retains clinical responsibility and acts as gatekeeper in the referral process.

We are currently experimenting with a model where the patient is given the option to choose whether he or she sees the general practitioner or goes directly to a complementary practitioner. A further experiment is that of the dissolution of the general practitioner partnership as the core to the structure of health care teams. The proposed model of a multiprofessional practice would involve some of the following possibilities:

- All clinicians and senior administrative staff would share ownership of premises
- Decision making would be delegated to a practice management group to include:

- one general practitioner selected by all the general practitioners
- one administrative member of staff (practice manager)
- one other clinician selected by the non-general practitioner clinical staff
- All clinical and administrative staff would be on salaried contracts, to reflect experience, status, qualifications, etc., and hours of work
- Profits would be shared equally among all staff and based on length of service and performance related indicators
- Medical accountability and liability would be a corporate and not individual concern
- Patients would be registered with the “practice” and not with the individual general practitioner.

This model will not appeal to many general practitioners struggling to maintain their autonomy and status, but the logic of all the recent NHS reforms points in this direction. My view is that although our roots may lie in medical schools and our current identity is that of general practice, our future lies as members and, at times, leaders of an expanded primary health and community care team which, among others, must include selected complementary practitioners.

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- 6 Magic or medicine? *Which?* August 1981.
- 7 Mori Poll. *Times* 13 Nov 1989.
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### ANY QUESTIONS

*Are there any recommendations or requirements in force for the cleaning, etc., of barbers' equipment to prevent the spread of bloodborne disease?*

There are no specific regulations dealing with this subject, but barbers, like any employers or self employed people, have a duty under the health and safety at work legislation to protect customers from risks to health and safety arising from work activities. Apart from the well known barber's rash (staphylococcal folliculitis; sycosis barbae), there is no evidence concerning the transmission of infection during tonsorial work.

Nowadays, concern is focused on the spread of viruses—for example, HIV and hepatitis—from blood contaminated instruments such as razors, scissors, and clippers. The risk is probably similar to that associated with ear piercing and tattooing and is determined by many factors, such as the prevalence of infection among the clients, frequency of cuts, numbers of virus particles shed on to instruments and their viability afterwards, and rates of seroconversion. It is generally accepted that about one

in 200 people become HIV positive after accidental inoculation with infected blood, but the figure for hepatitis B may be nearer to 20%. Although small nicks may not bleed much, as little as 1 µl of blood may be sufficient to transmit infection. We know little about the survival of these viruses outside the body, but current research suggests that HIV may remain viable in dried blood for several days and hepatitis B for several weeks.

The Department of Health and Social Security produced a booklet and a leaflet for hairdressers.<sup>1,2</sup> It recommended that only disposable razors or disposable cut throat blades should be used for shaving. Instruments that have become soiled with blood should be autoclaved or disinfected with, for example, hypochlorite solution or 70% alcohol, which are effective against HIV, hepatitis, and herpes viruses.—ALAN SCOTT, senior employment medical adviser, Health and Safety Executive, Nottingham

- 1 Department of Health and Social Security. *Acquired immune deficiency syndrome (AIDS) and skin piercing*. London: DHSS, 1987:9-17.
- 2 Department of Health and Social Security. *Government information leaflet. AIDS: guidelines for hairdressers and barbers*. London: DHSS, 1987.